

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05152
166

5158

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>GARRETT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <u>WILLIAM</u>	Middle <u>TURNEY</u>	Last <u>DE WEESE</u>	4. DATE OF DEATH	Month <u>MAY</u>	Day <u>- 21</u>	Year <u>1956</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY-30-1900</u>	9. AGE (in years lost birthday) <u>93 yrs.</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>		Months	Days
					Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GASOLINE DISTRIBUTOR.</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>ERWIN PA.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME <u>CHARLES DE WEESE</u>	14. MOTHER'S MAIDEN NAME <u>MARGARET SPIEGEL.</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>MRS. W.T. DE WEESE OAKLAND MD.</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>		<u>Immediate</u>
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Hypertensive Cardio-Vascular Disease</u>		YEARS
DUE TO (c) <u>Myocardial Infarction - OLD</u>		6 YRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
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20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from <u>4-18</u> , 19 <u>50</u> , to <u>5-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-21</u> , 19 <u>56</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.		
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ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE <u>James H. Feaster Jr.</u>	M.D. <u>58 2nd St. Oakland, Md 5-22-56</u>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY-23-1956</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>MEMORIAL CEMETERY</u>	22d. LOCATION (City, town, or county) <u>GREEN BURG Pa.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Emroy Bolden</u>	ADDRESS <u>OAKLAND MD.</u>	24a. REC'D. BY REGISTRAR <u>Julia & Roa</u>	24b. REGISTRAR'S SIGNATURE <u>RK</u>
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DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 25 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05153
166

5159 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland		c. LENGTH OF STAY IN 1b 71 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland		d. STREET ADDRESS 10 Mi. N W Oakland, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 Mi. N W Oakland, Md.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Theodosia	Middle Friend	Last DeWitt	4. DATE OF DEATH	Month May	Day 30,	Year 1956
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH April 17, 1885	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zadok Friend				14. MOTHER'S MAIDEN NAME Alice Friend			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Peder Baasland		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Heart Disease DUE TO Fears (c) Debility. DUE TO Fears							
INTERVAL BETWEEN ONSET AND DEATH 4 hrs							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-28-56 19 to 5-25 1956, that I last saw the deceased alive on 4-28 1956, and that death occurred at 8:55P M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 58 2nd St. Oakland, Md.							
DATE SIGNED 5-31-56							
ACTUAL SIGNATURE Jas. H. Feaster, Jr.							
PHYSICIAN'S NAME (Type) Jas. H. Feaster, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/1956		22c. NAME OF CEMETERY OR CREMATORIUM Hoyes Run Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton				ADDRESS Oakland, Md.			
24a. REC'D BY REGISTRAR 6/2/56				24b. REGISTRAR'S SIGNATURE Bell & Roway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE GOVERNMENT OF HAWAII—SALVATION IS

CERTIFICATE OF DEATH

NAME

ADDRESS

AGE

SEX

CAUSE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DEATH CERTIFICATE NO.

ISSUED BY

DATE

SIGNATURE

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

JUN 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5160 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) WILLIAM EDWARD DURST			First	Middle	Last	
4. DATE OF DEATH MAY 3 1956	Month	Day	Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 12, 1873	9. AGE (in years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Garrett Co., Md.		
13. FATHER'S NAME Hanson Durst			14. MOTHER'S MAIDEN NAME Charlotte Broadwater			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Pearl Durst, Swanton R.D. Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>E.J. Baumgartner</i>			DATE SIGNED <i>5/3/56</i>			
EXAMINER'S NAME (Type) E.J. BAUMGARTNER		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/6/56		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Dry Run Grantsville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Donald J. Newman</i>		22d. LOCATION (City, town, or county) Rural Swanton, Garrett Co., Md.		24a. REC'D BY REGISTRAR DATE V/14/56		
				24b. REGISTRAR'S SIGNATURE <i>A.H. Sedwick</i>		

REGISTRATION STATE OF HAWAII - BUREAU OF
MEDICAL EXAMINERS CERTIFICATE OF DEATH

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MAY 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5161

CERTIFICATE OF DEATH

05155

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Garrett		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finzel		c. LENGTH OF STAY IN 1b 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finzel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
GRACE			M.	EISLER	May	27	19	56

5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-1-1905	9. AGE (In years lost birthday) 50 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Lloyd A. Arnold	14. MOTHER'S MAIDEN NAME Susan Baker
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. none	17. INFORMANT Sam H. Eisler, Finzel, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		Ch. myocarditis - atherosclerosis Cardio renal vascular disease with severe hy pertension	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		30 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ _____ _____	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20c. TIME OF INJURY Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____
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21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above. ACTUAL SIGNATURE J. R. Durst, M.D.		ADDRESS (Street, city or town, state) 36 Green St Crimel and Md	DATE SIGNED May 27-56
PHYSICIAN'S NAME (Type)			

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-30-1956	22c. NAME OF CEMETERY OR CREMATORIUM Greenville Cemetery	22d. LOCATION (City, town, or county) Greenville, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE 5-30-56
			24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Ross

87 BROWNLINER-IT IS A 2017 GM STATE OWNED VEHICLE

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5162

CERTIFICATE OF DEATH

0515866
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sang Run		c. LENGTH OF STAY IN 1b 82 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sang Run		d. STREET ADDRESS one mile east Sang Run		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION one mile east Sang Run				d. STREET ADDRESS one mile east Sang Run		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Alfred		First	Middle Ira	Last Friend	4. DATE OF DEATH May 7,	Month May	Day 7	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Feb. 4, 1874	9. AGE (In years less birthday) 82 yrs.	IF UNDER 1 YEAR 82 Months	IF UNDER 24 HRS. 82 Days	IF UNDER 24 HRS. 82 Hours	IF UNDER 24 HRS. 82 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John F. Friend		14. MOTHER'S MAIDEN NAME Rachel Friend						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----		17. INFORMANT John F. Friend, Jr. Sang Run, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial , Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.0 (b) Sclerotic Heart Disease DUE TO (c) Senility						INTERVAL BETWEEN ONSET AND DEATH First attack		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 58 2nd St.		20f. (City or town) Oakland, Md.		(County) Oakland (State) Md.
21. I certify that I attended the deceased from 6-1 , 19 53 , to 4-17 , 19 56 , that I last saw the deceased alive on 4-27 , 19 56 , and that death occurred at 11:50 P.M. , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Oakland, Md.		DATE SIGNED 5-8-56
ACTUAL SIGNATURE James H. Feaster								
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/10/1956		22c. NAME OF CEMETERY OR CREMATORIUM J. F. Friend home Cem.		22d. LOCATION (City, town, or county) near Sang Run, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR Julia A. Ronan		24b. REGISTRAR'S SIGNATURE Julia A. Ronan		

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

155
MATERIALS STATE DEPARTMENT OF HEALTH - BALTIMORE 19
CERTIFICATE OF DEATH

BUREAU V. S.

MAY 17 1956

RECEIVED

1956

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5163

CERTIFICATE OF DEATH

05157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Accident		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Accident, Md.		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First ANNA	Middle ELIZABETH	Last GEORG	4. DATE OF DEATH May 17	Month May	Day 17	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 11, 1867	9. AGE (In years lost birthday) yrs. 88	IF UNDER 1 YEAR Months 88	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Mill Run, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME August Frederic		14. MOTHER'S MAIDEN NAME Neil Anne Elizabeth Klotz						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Raymond Georg, Daisytown, Pa.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arterosclerosis		Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 3 years				
(b) DUE TO Diabetes		Arterosclerosis		10 years				
(c) 2008		Diabetes		4 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from May 16 , 1956, to May 17 , 1956, that I last saw the deceased alive on May 17 , 1956, and that death occurred at 3:30 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. no# Maple St., Friendsville, Maryland				
ACTUAL SIGNATURE Milton Tepfer				DATE SIGNED				
PHYSICIAN'S NAME (Type) Milton Tepfer, M.D.				Friendsville, Maryland May 19, 1956				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/56		22c. NAME OF CEMETERY OR CREMATORIAL Zion Lutheran		22d. LOCATION (City, town, or county) Accident, Garrett Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman		ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR MAY 21 1956		24b. REGISTRAR'S SIGNATURE A. H. Hedrick		

WISCONSIN STATE DEPARTMENT OF HEALTH - SEALINEREF. #

CERTIFICATE OF DEATH

Wisconsin
Health
Department

10 N

BUREAU V.

MAY 21 1956

REGISTRATION

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Lynn

V.D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5164

CERTIFICATE OF DEATH

05159

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>GARRETT</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>GARRETT</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>STAR Route, Frostburg, Md.</i>		c. LENGTH OF STAY IN 1b <i>10 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>STAR Route, Frostburg, Md.</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>BETTY</i>	Middle <i>JEAN</i>	Last <i>LICHTY</i>	4. DATE OF DEATH <i>MAY</i>	Month <i>2</i>	Day <i>Year</i>
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 15, 1933</i>	9. AGE (In years lost, birthday) <i>12 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WORK</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Family Home</i>		11. BIRTHPLACE (State or foreign country) <i>GRANTSVILLE, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>EARL LICHTY</i>		14. MOTHER'S MAIDEN NAME <i>LEOSHA BUTLER</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>MR EARL LICHTY, STAR Route, Frostburg</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>multiple pulmonary abscesses</i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic bilateral bronchiectasia</i>		DUE TO <i>—</i>				16 years	
DUE TO <i>—</i>		(c) <i>—</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>May 30, 1956</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State) <i>Salisbury, Penna</i>	
21. I certify that I attended the deceased from <i>April 30, 1956</i> , to <i>May 2, 1956</i> , that I last saw the deceased alive on <i>May 1, 1956</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Salisbury, Pa</i>	
ACTUAL SIGNATURE <i>A. Paige Strong</i>		M.D.				DATE SIGNED <i>5/3/56</i>	
PHYSICIAN'S NAME (Type) <i>A. PAIGE STRONG</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>5/6/56</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>MT ZION</i>		22d. LOCATION (City, town, or county) (State) <i>STAR Route, Frostburg, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Donald J. Newman</i>		ADDRESS <i>GRANTSVILLE, MD</i>		24a. REC'D BY REGISTRAR <i>MAY 7 1956</i>		24b. REGISTRAR'S SIGNATURE <i>A. St. Hedrick</i>	

RECEIVED
FBI - WASH. D. C.
MAY 7 1956

U. S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASH. D. C.

CERTIFICATE OF DEATH

SEARCHED

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BUREAU V. S

MAY 7 1956

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1
M**INSTRUCTIONS**

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**5165 CERTIFICATE OF DEATH**

05160

Reg. Dist. No.....

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY	Garrett		STATE	Maryland COUNTY Garrett 166	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		
TOWN Rural Oakland		15 yrs	Rural Oakland		X
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		
Sunnyside			Sunnyside		
3. NAME OF DECEASED (First) James (Middle) Robert (Last) LUDWIG			4. DATE OF DEATH May 23, 1956		
5. SEX male		6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Sept. 20, 1872	9. AGE last birthday 83 yrs.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner		10b. KIND OF BUSINESS OR INDUSTRY Coal	11. BIRTHPLACE (State or foreign country) Rio, West Va.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Phillips George Ludwig			14. MOTHER'S MAIDEN NAME Elizabeth Oats		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Lee Ludwig, Baltimore, Md.		
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>450.0 IMMEDIATE CAUSE (A) Dilatular Heart Disease</i>					
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <i>Arterio Sclerosis</i>					
(C) <i>Age</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION <i>Dec 1954</i>		19b. MAJOR FINDINGS OF OPERATION		19c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 19 to 19 , that I last saw the deceased alive on May 23, 1956, and that death occurred at 11:30 A.M. from the causes and on the date stated above. SIGNATURE <i>J.W. Duncan</i> M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 27, 1956		NAME OF CEMETERY OR CREMATORIAL Odd Fellow Cem.	
24. REC'D BY REGISTRAR DATE May 24/56		REGISTRAR'S SIGNATURE <i>Jules Brown L.R.</i>		LOCATION (City, town, or county) Elk Garden, W.Va.	
25. FUNERAL DIRECTOR'S SIGNATURE J.D. Duncan <i>John Duncan</i> Thomas, W.Va.					

BUREAU V. S.

MAY 31 1958

REFUGEE

TO HOSPITAL
may be referred by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5166

CERTIFICATE OF DEATH

05161
0966

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY PRESTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TERRA ALTA		d. STREET ADDRESS ROUTE 3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First ASA	Middle RAY	Last SISLER	4. DATE OF DEATH MAY 14 1956	Month MAY	Day 14	Year 1956
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 11, 1896	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) TERRA ALTA, W. VA.		12. CITIZEN OF WHAT COUNTRY? UNITED STATES		
13. FATHER'S NAME ISAAC CLINTON SISLER				14. MOTHER'S MAIDEN NAME SARAH SMITH				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 236-03-9004		17. INFORMANT Mrs. Ethel May Sisler, Terra Alta, W.Va.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pericardial Effusion with Impairment + Anuria</i> INTERVAL BETWEEN ONSET AND DEATH 3 days 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Metastatic Bronchogenic Carcinoma</i> 2 years DUE TO (c) <i>and Atelectasis, Left lung + Pulmonary edema</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Terra Alta, W. Va.	(County)	(State)
21. I certify that I attended the deceased from April 23, 1956 , to May 14, 1956 , that I last saw the deceased alive on May 13, 1956 , and that death occurred at 9:42 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Terra Alta, W. Va. DATE SIGNED 5/15/56								
ACTUAL SIGNATURE <i>Chas. E. Smith, M. D.</i>								
PHYSICIAN'S NAME (Type)		Terra Alta, West Virginia.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 17, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Terra Alta Cemetery		22d. LOCATION (City, town, or county) Terra Alta, W. Va. (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. R. Watson</i>		ADDRESS Terra Alta, W. Va.						
24a. REC'D. BY REGISTRAR 5/16/56		24b. REGISTRAR'S SIGNATURE <i>Julia P. Rowan LR</i>						

CERTIFICATE OF DEATH

BUREAU J.V.
RECEIVED
MAY 25 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5167 CERTIFICATE OF DEATH

05162
166
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE WEST VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PETERSBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 85X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD		First	Middle	Lost	4. DATE OF DEATH MAY 29 1956
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH MARCH 24, 1870	9. AGE (In years lost birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME SAMSON SMITH		14. MOTHER'S MAIDEN NAME SUSAN SMITH CARR.		Address Tracy Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT TRACY SMITH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		INTERVAL BETWEEN ONSET AND DEATH Chronic heart failure Chronic myocarditis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic bronchitis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1956, to May 19, 1956, that I last saw the deceased alive on May 19, 1956, and that death occurred at 4:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Physician's NAME (Type)				ADDRESS (Street, city or town, state) M.D. 254 Cedar St Bellwood (Marlboro)	
22a. BURIAL/CREMATION REMOVAL (Specify) June 7, 1956		22b. DATE THEREOF Smith Family Cemetery		22d. LOCATION (City, town, or county) Mayesville W. Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J Blaine Schaeffer - Petersburg		ADDRESS 85X-3		24c. REC'D BY REGISTRAR DATE JUN 7 1956 24d. REGISTRAR'S SIGNATURE Julia Rawley	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be referred by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and many event within 72 hours after death.

CHIEF COUNSEL TO DEATH

WISCONSIN STATE DEPARTMENT OF HUMAN SERVICES

BUREAU V. 2

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1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1805163

Item 9 Film G197 5-11-56

5168

CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin		d. STREET ADDRESS Box 74	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Nute	Middle Sam	Last Stiles	4. DATE OF DEATH May 1 1956	Month May	Day 1	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 2, 1889	9. AGE (In years last birthday) 66 6/12 yrs.	IF UNDER 1 YEAR Months 66	IF UNDER 24 HRS. Days 6	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired COAL MINER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME La Fayette Stiles (Deceased)				14. MOTHER'S MAIDEN NAME Harriett Garby (Deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Nute S. Stiles, Box 74, Crellin, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 484.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) 10 days						INTERVAL BETWEEN ONSET AND DEATH	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oakland Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/30/56 , 1956, to 5/1 , 1956, that I last saw the deceased alive on 4/30/56 , 1956, and that death occurred at 11:03 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas E. Lusby				ADDRESS (Street, city or town, state) Oakland Md. DATE SIGNED 5/1/56			
PHYSICIAN'S NAME (Type) Thomas E. Lusby							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 5-1956		22c. NAME OF CEMETERY OR CREMATORIUM ASHBY CEMETERY		22d. LOCATION (City, town, or county) NEAR CRELLIN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emroy Bolden OAKLAND MD		24a. REC'D BY REGISTRAR Julie O'Rourke RR					
		24b. REGISTRAR'S SIGNATURE Julie O'Rourke RR					

REGISTRATION STATE DEPARTMENT OF JUSTICE - BUREAU OF
CERTIFICATE OF DEATH

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BUREAU V. S.

MAY 7 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5169

CERTIFICATE OF DEATH

0516466
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Garrett				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, Md.		c. LENGTH OF STAY IN 1b 6 mon.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kayser Nursing Home		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First HOWARD	Middle RICHARD	Last SWAUGER	4. DATE OF DEATH May 13	Month Year 1956			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 1, 1879	9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) woodsmen		10b. KIND OF BUSINESS OR INDUSTRY cutting posts		11. BIRTHPLACE (State or foreign country) Grantsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Issac Swauger				14. MOTHER'S MAIDEN NAME Virginia Layman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Charles Swauger, Grantsville, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Coronary Occlusion Coronary Sclerosis (c) INTERVAL BETWEEN ONSET AND DEATH 1 min 5 yrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>Jan 1, 1956</u> , to <u>May 13, 1956</u> , that I last saw the deceased alive on <u>May 11, 1956</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Arthur F. Jones</u> M.D. ADDRESS (Street, city or town, state) <u>Oakland, Md.</u> DATE SIGNED								
PHYSICIAN'S NAME (Type)		ARTHUR F. JONES						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/56		22c. NAME OF CEMETERY OR CREMATORIUM New Germany Reformed		22d. LOCATION (City, town, or county) (State) Grantsville, R.D. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman		ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR John J. Brown		24b. REGISTRAR'S SIGNATURE John J. Brown		

STATE OF NEVADA - SALINAS

CERTIFICATE OF DEATH

DECEASED
NAME

DEATH DATE

AGE AT DEATH

BUREAU

MAY 23

R. E. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5170

CERTIFICATE OF DEATH

05165/66
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First ESTELLA	Middle FRANTZ	Last SWEENEY	4. DATE OF DEATH Month MAY - 26	Year 1956
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH MARCH - 7 - 1884	9. AGE (In years lost birthday) 72 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) SELBYSPORT MD	12. CITIZEN OF WHAT COUNTRY? U.S.
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13. FATHER'S NAME EDWARD FRANTZ	14. MOTHER'S MAIDEN NAME MARY DUNHAM	Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT PERCY FRANTZ
		OAKLAND MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Myocardial Heart Disease		3 mos
(b) Arteriosclerosis		4 years
(c) Arteriosclerosis		10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Oakland	(County)	(State)

21. I certify that I attended the deceased from 1955 to 26 May, 1956 , that I last saw the deceased alive on 26 May, 1956 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE A. E. Mance	M.D.	ADDRESS (Street, city or town, state) Oakland, Md.	DATE SIGNED 27 May 1956		

PHYSICIAN'S NAME (Type) A. E. Mance, M. D.	22c. NAME OF CEMETERY OR CREMATORIAL OAKLAND CEMETERY	22d. LOCATION (City, town, or county) OAKLAND M.D.
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY-29-1956	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden	ADDRESS OAKLAND MD	24a. REC'D BY REGISTRAR 5/29/56
		24b. REGISTRAR'S SIGNATURE James R. Long

WISCONSIN STATE GOVERNMENT OF HESSEN-BALTIMORE 18

CERTIFICATE OF DEATH

CEMETERY

MARSHALL VILLE

1956

BUREAU Y. S.

JUN 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5171

CERTIFICATE OF DEATH

05166 6

Reg. Dist. No.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death; by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LAKE PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HAROLD		First O.	Middle TEAGARDEN
4. DATE OF DEATH MAY 25 1956	Month MAY	Day 25	Year 1956
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH MARCH-23-1887
8. AGE (In years lost birthday) 69 yrs.	9. IF UNDER 1 YEAR Months 69	10. IF UNDER 24 HRS. Days 0	11. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME SONAS TEAGARDEN		14. MOTHER'S MAIDEN NAME EMMA WISE.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. MARBLE TEAGARDEN		Address MT. LAKE PARK	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Congestive heart disease		INTERVAL BETWEEN ONSET AND DEATH 1/2 days	
(b) DUE TO Congestive heart disease		1 Year	
(c) Altered Sclerosis		3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 , to MAY 25 , 1956, that I last saw the deceased alive on MAY 25 , 1956, and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Francis		ADDRESS (Street, city or town, state) Oakland Md	
PHYSICIAN'S NAME (Type)		DATE SIGNED 26 May 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY-28-1956	
22c. NAME OF CEMETERY OR CREMATORIUM EGDON CEMETERY		22d. LOCATION (City, town, or county) EGDON	
23. FUNERAL DIRECTOR'S SIGNATURE Emroy Bolden		24a. REC'D BY REGISTRAR DATE 5/26/56	
ADDRESS OAKLAND MD		24b. REGISTRAR'S SIGNATURE Dulie Rowan	

DEPARTMENT OF HEALTH-EARLY CHILDHOOD

CERTIFICATE OF DEATH

1956

REGISTRATION

BUREAU V.

MAY 31 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

Vs AISC 1-51 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5172

CERTIFICATE OF DEATH

05167

Reg. Dist. No.....

1. PLACE OF DEATHCOUNTY **Garrett**CITY (If outside corporate limits, write RURAL
OR end give nearest town)

TOWN

Shady Mill, Garrett Co.

MARYLANDLENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Star Route, Frostburg, Md

2. USUAL RESIDENCE (HOME) OF DECEASEDSTATE **Maryland**COUNTY **Garrett**

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

Shady Mill, Garrett Co.

STREET

ADDRESS

Star Route, Frostburg, Maryland

**3. NAME OF
DECEASED**
(Type or Print)**WILLIAM****LEWIS****TURNER**

(First)

(Middle)

(Last)

4. DATE

(Month)

(Day)

(Year)

May 24, 1956 19

(Type or Print)

Male

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Widowed

8. DATE OF BIRTH

June 29, 1869

9. AGE last birthday

86

10. IF UNDER 1 YEAR

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Dairyman

10b. KIND OF BUSINESS
OR INDUSTRY

Own Dairy

11. BIRTHPLACE (State or foreign country)

Garrett County, Maryland U S A

**12. CITIZEN OF WHAT
COUNTRY?****13. FATHER'S NAME**

JOSHUA

TURNER

14. MOTHER'S MAIDEN NAME

ELIIRA

CURLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESSStar Route,
William Turner, Frostburg, Maryland**I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

420.0 IMMEDIATE CAUSE

(A)

Chronic myocardial degeneration

5 years

ANTECEDENT CAUSE(S) DUE TO

(B)

Arteriosclerotic heart disease

10 years

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO

(C)

Generalized arteriosclerosis

10 yrs

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.****19e. DATE OF OPERATION**

None

19b. MAJOR FINDINGS OF OPERATION**20. AUTOPSY?**YES NO 21e. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)**21c. WHERE DID INJURY OCCUR? (City or town)**

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?While Not while
at work at work

M.

22. I hereby certify that I attended the deceased from April 23, 1956, to May 23, 1956, that I last saw the deceased alive on May 23, 1956, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

SIGNATURE

A. Paige Strong

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

REGISTRAR'S SIGNATURE

NAME OF CEMETERY OR CREMATORIUM

M.D.

Salisbury Penna. May 24, 1956

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

May 26, 1956

REGISTRAR'S SIGNATURE

M. H. Hendrich

25. FUNERAL DIRECTOR'S SIGNATURE

John J. Hafer, Cumberland, Md.

ADDRESS

DEPARTMENT OF HAWAIIAN-AMERICAN STATE DEPARTMENT

CHIEF OF POLICE

BUREAU V. S.

MAY 29 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5173 CERTIFICATE OF DEATH

05168/6
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE MARYLAND		b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LAKE PARK.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First FLAVIOUS	Middle JOSEPH	Last TURNEY	4. DATE OF DEATH Month MAY - 25	Day Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH APRIL-9-1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>						

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) FRIENDSVILLE MD	12. CITIZEN OF WHAT COUNTRY? U.S.
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13. FATHER'S NAME ISAAC TURNEY	14. MOTHER'S MAIDEN NAME NANCY JANE MEYERS
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 216-10-3616	17. INFORMANT JOSEPH TURNEY MT. LAKE PARK MD.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINO - a OR NECIC 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-Sclerotic heart Disease DUE TO (c)	1 YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from 7-18 , 19 56 , to 5-25 , 19 56 , that I last saw the deceased alive on 5-25-56 , 19 56 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above.		
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ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE Jean H. Turner Jr.	M.D.	5-28-56	5-28-56
PHYSICIAN'S NAME (Type)	OAKLAND Twp.		

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY-28-1956	22c. NAME OF CEMETERY OR CREMATORIUM OAKLAND CEMETERY	22d. LOCATION (City, town, or county) OAKLAND
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23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden	ADDRESS OAKLAND MD.	24a. REC'D BY REGISTRAR DATE 5/28/56	24b. REGISTRAR'S SIGNATURE Julia H. Powers LP
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